



CHERRYHILL
CHIROPRACTIC

Dr. Scott Watson

Patient Information (Please Print)

Name: _____ Gender: _____
Address: _____ City: _____
Province: _____ Postal Code: _____ Home Phone: _____ Cell Phone: _____
Birth Date (D/M/Y): ___ / ___ / ___ Age: _____ Marital Status: S M D W
Email _____
Emergency contact: _____ Phone Number: _____
Have you attended another chiropractor? Y N Name: _____
Last seen (D/M/Y): ___ / ___ / ___ Reason for visit: _____
Referred by: _____

Employer Information

Employer: _____ Occupation: _____

Insurance company _____ Policy # (Plan certificate #) _____ Member ID # (member certificate #) _____

Physician Information

Medical Doctor: _____ City: _____ Phone: _____

Date of last physical (D/M/Y): ___ / ___ / ___

May we contact and/or send medical information to your medical doctor? Y N

Cherryhill Chiropractic
101 Cherryhill Blvd. Suite 113
London, ON N6H 4S4
T:519-433-7281 F:519-433-9504

Information of Condition

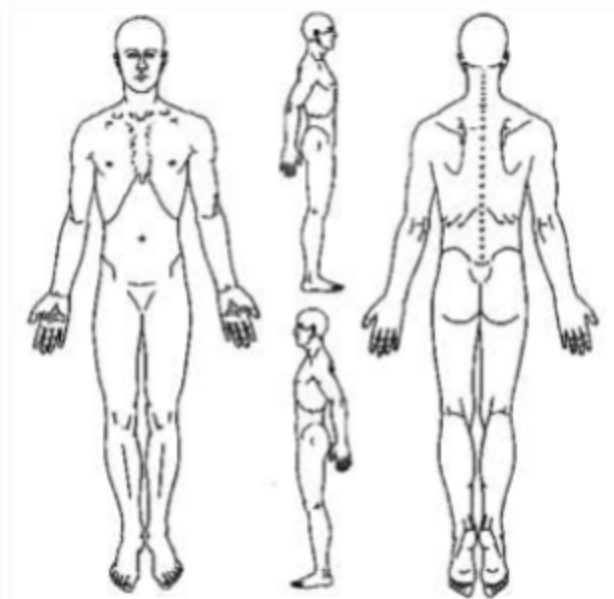
What is the main reason for this visit? _____

When did this problem start? _____ How? _____

Any additional complaints? _____

On the diagram below, please indicate where you are experiencing pain now and use the appropriate symbol as indicated

- Ache //////////////
- Burning BBBBBB
- Numbness NNNNN
- Pins & Needles ++++++
- Stabbing XXXXX
- Stiffness ^^^^^^^
- Weakness WWWW



Please make a slash through this line to the level of your current pain
 No pain at all |-----| Worst Pain Possible

The symptoms are (Please Circle): Constant Intermittent Worse with movement Better with movement

Worse in the a.m. Worse in the p.m. Getting better Getting worse No change

I am experiencing (Please Circle): Numbness Weakness Swelling Weight changes Night Sweats

Fever Changes in bowel/bladder frequency or urgency

What makes your symptoms worse? (Please Circle): Standing Walking Lifting Exercise

Twisting Bending Sitting Coughing/Sneezing Lying Down: Side Back Stomach

Using Stairs: Up Down Both Other: _____

What makes your symptoms better? (Please Circle): Rest Elevation Ice Heat

Position: _____ Other: _____

Medications/Vitamins/Supplements: _____

Past Medical History

Have you ever been in an automobile accident? Y N Date: _____

Any difficulties/injuries resulting from this incident? _____

Please list surgeries and year performed: _____

Please indicate if you have every had any of the following?

Cardiovascular

- High/Low Blood Pressure
- Heart Attack
- Stroke
- Aneurysm
- Pace Maker
- Heart Disease
- Other: _____

Infection

- Hepatitis
- TB
- HIV
- Skin
- Chicken Pox
- Other: _____

Previous Injuries

- Head/Neck
- Upper Back
- Mid Back
- Lower Back
- Shoulders/Arms
- Wrist/Hands/Fingers
- Pelvis
- Legs/Knees
- Ankles/feet/toes

Other Conditions

- Diabetes
- Cancer
- Arthritis: OA/RA
- Osteoporosis
- Epilepsy
- Psoriasis
- Fibromyalgia
- Fatigue
- Concussion
- Allergies: _____
- Other: _____

Respiratory

- Shortness of Breath
- Asthma
- Bronchitis
- Emphysema/COPD
- Pneumonia
- Other: _____

Head/Neck

- Headaches
- Migraines
- Vision Problems
- Hearing Problems
- Sinus Condition
- Other: _____

Women

Are you currently pregnant? Y N

If yes, due Date: _____

Signature: _____ Date: _____